Pacific Medical Care

WORKERS COMPENSATION INFORMATION

pacificmedicalcare.net

Phone: 619-333-8114 **Fax: 619-461-5663**

WORKER'S COMPENSATION INFORMATION

Name: _____ DOB: _____

Date of Injury: _____ Are you currently working? _____

If you are not currently working, is it as a result of this injury? _____

What date were you taken out of work? _____

Who took you out of work? _____

Employer name and address at the time of injury: _____

_____

_____

WCB#: _____Carrier Case#: _____

Name and address of insurance company: _____

_____

_____

Phone number of insurance company: _____

Name of contact person at the insurance company:_____

Fax number of contact person:_____

Name of your lawyer: _____

Phone number of your lawyer: _____

What body part(s) the case is open for:_____

****If case is closed please provide a copy of the final award, stipulation Order or Compromise and Release.*

This information must be filled out and returned to our office before your scheduled appointment. If we do not receive this information, your appointment may be rescheduled.